STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN ROAD FORT WAYNE, IN46815

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F0000	This visit was for the investigation of Complaint Number IN00087424. Complaint Number IN00087424- Substantiated, State/Federal deficiencies related to the allegation are cited at F223, F333, and F514 Survey dates: April 7, 8, 2011 Facility number: 000282 Provider number: 155755 AIM number: 100287520 Survey team: Ann Armey, RN- TC Diane Nilson, RN Census bed type: SNF/NF: 106 Total: 106 Census payor type: Medicare: 8 Medicaid: 79 Other: 19 Total: 106 Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after April 27, 2011.This provider further respectfully requests a desk review in which our documents for verification of compliance are being delivered via USPS to Ms. Kim Rhoades.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on April 14, 2011 by Bev Faulkner, RN			
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
SS=A	Based on interview and record review, the facility failed to assure a resident was free from verbal abuse. This deficiency involved 1 of 2 staff persons (CNA #10) investigated for alleged abuse for 1 of 2 (Resident #G) residents in a sample of 8. Findings include: The clinical record of Resident #G was reviewed on 4/8/11 at 2:00 p.m., and indicated the resident was admitted to the facility on 11/3/09 with diagnoses which included but were not limited to, Alzheimer's Disease and depression. Physician's orders, dated 2/11/11, indicated Resident #G was to be admitted to hospice with a diagnoses of dementia. A significant change Minimum Data Set assessment, dated 2/22/11, indicated the	F0223	F 0223It is the practice of this provider to ensure residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This provider does not allow verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no negative outcomes for the resident alleged to have been affected by the deficient practice. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The employee was immediately	04/26/2011

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	resident had severe cognitive impairment and required extensive assistance for transfer, dressing, hygiene and toileting. On 4/8/11 at 3:00 p.m., Resident #G responded "no" when asked if she had any concerns about the way she was treated. A facility incident reporting form, dated 3/3/11, was reviewed on 4/8/11 at 3:05 p.m., and indicated Resident #G's daughter reported she overheard CNA #10 yelling at her mother in the bathroom. The incident report indicated Resident #G stated that CNA #10 "was mean" to her. The report indicated, Resident #G was examined, after the incident and the employee was suspended. The report further indicated the Indiana State Department of Heath was notified and following an investigation, CNA #10 was terminated. The termination notice, dated 3/4/11, was reviewed on 4/8/11 ay 3:10 p.m., and indicated "On 3/3/11 at 7pm, (Resident #G's initials) daughter reported above name employee (CNA #10) was yelling at her Mother while assisting her in the bathroom...This matter was thoroughly investigated and it was substantiated employee was verbally abusive to resident....employee is being terminated for violating nursing home standards and		terminated therefore no other residents had the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** This provider's system is as follows: -Pre-employment interviews are conducted -Pre-employment reference checks are conducted -Employment criminal background checks are completed -Employees are trained upon hire and routinely thereafter on abuse and neglect policy and procedure -Proper authorities are notified of abuse and neglect allegations -This provider has a zero tolerance for abuse and neglect, therefore any allegations of such incidents will warrant immediate termination. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** All staff were in-serviced by the Administrator and/or Director of Nursing Services or designees between March 4-March 20, 2011 regarding this provider's abuse and neglect policy and procedure, caring for combative residents and resident rights. Administrator or designee will monitor continued compliance through monthly random employee interviews regarding	

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	the Company's business conduct policies in regards to: Resident Abuse." On 4/8/11 at 3:15 p.m., the Director of Nursing confirmed CNA #10 had been terminated for verbal abuse. Inservice reports were reviewed on 4/8/11 at 3:20 p.m., and indicated, after the incident, all employees were inserviced, between 3/4/11 and 3/20/11, on abuse/neglect, caring for combative residents and resident rights. The policy for Prevention of Resident Abuse and Neglect, dated 7/12/10, provided by the Director of Nursing , was reviewed on 4/8/11 at 3:30 p.m., and indicated "Each resident living in this community has the right to be free from abuse, neglect and misappropriation of their property... "Verbal Abuse" is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families..." This federal tag relates to Complaint Number IN00087424. 3.1-27(b)		our abuse and neglect policy x 6 months. The Administrator will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on observation, record review, and interview, the facility failed to ensure 1 resident, in a sample of 2 residents reviewed for medication errors, Resident # H, was free of medication errors. Findings included: 1. Review of a Medication Error Report, dated 3/23/11, indicated Spiriva 18 micrograms (mcg), handihaler, one puff every day at 6:00 a.m. was ordered to be given to Resident #H. The report indicated an error was made between November 2010 and March, 2011. The type of error indicated, "failure to dispense medication" and the reason indicated, "Did not reorder medication as needed. " The Description of the error indicated the medication was initialed as given (between November 2010 and March 2011). However, the Pharmacy indicated the medication had not been re-ordered since October 9, 2010. An audit of the medication cart, completed 3/23/11, revealed the medication was not in the medication cart and was re-ordered on 3/23/11. The corrective action taken indicated,	F0333	F333It is the practice of this provider to ensure that residents are free of any significant medication errors.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No negative outcomes occurred as a result of our alleged deficient practice. Resident H: A medical assessment was completed on 3/23/11 with no negative findings.Resident H: The Spiriva order was discontinued per family physician on 4/12/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% resident Medication Administration Record audit was completed on 4/11/2011 with no further residents receiving Spiriva. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** -Interdisciplinary team will meet Mon-Fri excluding holidays to review each physician's order so we can immediately identify any new Spiriva orders. All Licensed Nurses were trained on the	04/26/2011

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	"Disciplinary action to nurses involved. Physician notified and medication discontinued. " The clinical record of Resident #H was reviewed on 4/8/11 at 2:05 p.m., and indicated the resident had diagnoses which included but were not limited to, Chronic Obstructive Pulmonary Disease. Current signed physician orders, for March 2011, indicated Spiriva 18 mcg handihaler, inhale contents of one capsule orally, once daily, at 6:00 a.m. The MAR (Medication Administration Record) for March 2011, indicated the medication was originally ordered March 18, 2009, and was initialed as given every day at 6:00 a.m., for the entire month of March. The MAR for April, 2011, indicated the medication was initialed as given at 6:00 a.m., on April 1,2,4,5, 6, 7, and 8, 2011. There were no initials documented for April 3, 2011. At 3:00 p.m., on 4/8/11, accompanied by the Director of Nursing Services (DNS), the Spiriva for Resident #H was observed in the medication cart in a box. The DNS counted the capsules in the box and 24 capsules remained in the medication box. The DNS indicated 30 capsules had been sent on 3/23/11, so 6 capsules were missing from the medication box.		following by the Director of Nursing Services or designee on 4/18-4/20/2011:-Re-ordering medications policy and procedure -Spiriva manufacturer's insert for proper administration was reviewed-Policy & Procedure for accurately administering and documenting medications -Reviewed the procedure of using a medication count sheet when using Spiriva **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** -Director of Nursing Services or designee will monitor our pharmacy software for medications reorder dates at least monthly x 6 months.-Administrator or designee will monitor continued compliance through monthly random MAR audits x 6 months. The Administrator and/or designee will document findings on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

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	At 4:05 p.m., on 4/8/11, the Community Nurse Leader #1, indicated he had contacted the pharmacy after the medication was counted, and the pharmacy indicated the box of Spiriva, 30 capsules, was sent on 3/23/11 and the only box prior to 3/23/11, was sent in October, 2010. Community Nurse Leader #1 indicated he had audited the medication carts in March, 2011, and discovered there was no Spiriva for Resident #H in the medication cart and contacted the pharmacy at that time, and was informed the last time the Spiriva was ordered was in October, 2010. At 4:10 p.m. on 4/8/11, the DNS indicated, although the Medication Error Report , dated 3/23/11, had indicated the physician was notified after the error was discovered and the medication was to be discontinued, the medication had not been discontinued. The DNS indicated the physician had been notified and wanted the medication to be continued on a daily basis. Review of the MAR for March, 2011, indicated the Spiriva had been initialed as given daily at 6:00 a.m., between 3/23/11 (when it was re-ordered) and March 31, 2011.			

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	Review of the MAR for April, 2011, indicated the Spiriva had been initialed as given at 6:00 a.m., on April 1, 2, 4, 5, 6, 7, and 8, 2011. Therefore, although initials documented on the MAR for March and April, 2011, indicated the medication had been given 15 times since March 23, 2011, when it was re-ordered, only 6 capsules were missing from the medication box sent on 3/23/11. This federal tag relates to Complaint Number IN00087424. 3.1-25(b)(9) 3.1-48(c)(2)			
F0514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient			

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	information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
SS=D	Based on observation, record review, and interview, the facility failed to maintain clinical records that were accurately documented as nursing staff documented the administration of a medication when the medication had not been re-ordered for nearly 5 months and then once re-ordered was not administered routinely but was initialed as given. This deficiency affected 1 resident, Resident # H, in a sample of two residents reviewed for medication errors. Findings include: 1. Review of a Medication Error Report, dated 3/23/11, indicated Spiriva 18 micrograms (mcg), handihaler, one puff every day at 6:00 a.m. was ordered to be given to Resident #H. The report indicated an error was made between November 2010 and March, 2011. The type of error indicated, "failure to dispense medication" and the reason indicated, "Did not reorder medication as needed. " The Description of the error indicated the medication was initialed as given (between November 2010 and March 2011). However, the Pharmacy indicated	F0514	F514It is the practice of this provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record contains sufficient information to identify the resident; a record of the resident's assessment; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No negative outcomes occurred as a result of our alleged deficient practice. Resident H: A medical assessment was completed on 3/23/11 with no negative findings.Resident H: The Spiriva order was discontinued per family physician on 4/12/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A 100% resident Medication Administration Record audit was	04/26/2011

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	the medication had not been re-ordered since October 9, 2010. An audit of the medication cart, completed 3/23/11, revealed the medication was not in the medication cart and was re-ordered on 3/23/11. The corrective action taken indicated, "Disciplinary action to nurses involved. Physician notified and medication discontinued. " The clinical record of Resident #H was reviewed on 4/8/11 at 2:05 p.m.. and indicated the resident had diagnoses which included but were not limited to, Chronic Obstructive Pulmonary Disease. Current signed physician orders for March 2011, indicated Spiriva 18 mcg handihaler, inhale contents of one capsule orally, once daily, at 6:00 a.m. The MAR (Medication Administration Record) for March 2011, indicated the medication was originally ordered March 18, 2009, and was initialed as given every day at 6:00 a.m., for the entire month of March 2011. The MAR for April, 2011, indicated the medication was initialed as given at 6:00 a.m., on April 1,2,4,5, 6, 7, and 8, 2011. There were no initials documented for April 3, 2011. At 3:00 p.m., on 4/8/11, accompanied by the Director of Nursing Services (DNS),		completed on 4/11/2011 with no further residents receiving Spiriva. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** -Interdisciplinary team will meet Mon-Fri excluding holidays to review each physician's order so we can immediately identify any new Spiriva orders. All Licensed Nurses were trained on the following by the Director of Nursing Services or designee on 4/18-4/20/2011:-Re-ordering medications policy and procedure -Spiriva manufacturer's insert for proper administration was reviewed-Policy & Procedure for accurately administering and documenting medications -Reviewed the procedure of using a medication count sheet when using Spiriva **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** -Director of Nursing Services or designee will monitor our pharmacy software for medications reorder dates at least monthly x 6 months.-Administrator or designee will monitor continued compliance through monthly random MAR audits x 6 months. The Administrator and/or designee will document findings	

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	the Spiriva for Resident #H was observed in the medication cart in a box. The DNS counted the capsules in the box and 24 capsules remained in the medication box. The DNS indicated 30 capsules had been sent on 3/23/11, so 6 capsules were missing from the medication box. At 4:05 p.m., on 4/8/11, the Community Nurse Leader #1 indicated he had contacted the pharmacy after the medication was counted and the pharmacy indicated the box of Spiriva, 30 capsules, was sent on 3/23/11, and the only box prior to 3/23/11 was sent in October, 2010. Community Nurse Leader #1 indicated he had audited the medication carts in March, 2011, and discovered there was no Spiriva for Resident #H in the medication cart and contacted the pharmacy at that time, and was informed the last time the Spiriva was ordered was in October, 2010. At 4:10 p.m. on 4/8/11, the DNS indicated, although the Medication Error Report, dated 3/23/11, had indicated the physician was notified after the error was discovered and the medication was to be discontinued, the medication had not been discontinued. The DNS indicated the physician had been notified and wanted the medication to be continued on a daily		on a Quality Improvement Tool and report the results of this audit to the Quality Assurance committee who will determine the frequency of further audits.	

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	basis. Review of the MAR for March, 2011, indicated the Spiriva had been initialed as given daily at 6:00 a.m., between 3/23/11 (when it was re-ordered) and March 31, 2011. Review of the MAR for April, 2011, indicated the Spiriva had been initialed as given at 6:00 a.m., on April 1, 2, 4, 5, 6, 7, and 8, 2011. Therefore, although initials documented on the MAR for March and April, 2011, indicated the medication had been given 15 times since March 23, 2011, when it was re-ordered, only 6 capsules were missing from the medication box sent on 3/23/11. This federal tag relates to Complaint Number IN00087424. 3.1-50(a)(2)			

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